MDR: M4-02-2554-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,284.06 for date of service 04/16/01.

   b. The request was received on 03/18/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA 1450/UB-92
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Example EOBs from other Carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. Carrier payment methodology for Texas ASCs
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/23/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 04/25/02. The response from the insurance carrier was received in the Division on 05/06/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor's representative states in the correspondence, dated 04/11/02, "We are appealing the amount disallowed on the above mention [sic] claim. These charges are for **FACILITY FEES**, not professional fees. We feel that 22% paid on a left knee arthroscopic & debridement with a lateral release is not fair or reasonable. We feel that (Carrier) should reimburse us more appropriately as $1182.97 does not cover our cost to perform this surgery…. (Carrier) has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85%-100% of our billed charges, and group carriers are allowing 100% of our billed charges. Enclosed are examples of bills for the same and similar type of treatment of other patients and their insurance companies interpretation of fair and reasonable as shown by the amounts paid…"

2. Respondent: The respondent's representative states in the correspondence, dated 05/03/02, (Requestor) "…has failed to establish that the reimbursement it seeks for facility charges complies with the Texas Workers' Compensation Act or TWCC Rules. Likewise, (Requestor) has failed to establish that the reimbursement paid by (Carrier) fails to comply with the Act and Rules."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 04/16/01.

2. The provider billed the carrier $5,467.03 for services rendered on 04/16/01.

3. The carrier reimbursed the provider $1,182.97 for date of service 04/16/01.

4. The amount in dispute, per the provider representative, is $4284.06 for 04/16/01.

5. The facility provided O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy, Radiology services, anesthesia equipment, EKG/ECG monitor, and Recovery Room services.
6. The carrier denied the billed charges by denial code ":M –No MAR/ASC reimbursement is based on fees established to be fair and reasonable in your geographical area., reduced to fair and reasonable, on the initial denial and on reconsideration. This decision will address only those denial codes the provider was aware of prior to filing for dispute resolution

V. RATIONALE

Medical Review Division's rationale:

Per the Texas Worker's Compensation Act and Rules §413.011(d), "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The medical reports indicate that the services were performed on a worker with the ICD-9 Code of 717.9. The EOB(s) from other insurance carriers submitted by the Requestor show similar ICD-9 Codes. All of the EOB(s)submitted do show that the Requestor was paid at 80%-100% of the billed charges.

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable. Regardless of the carrier's methodology or lack thereof, or a timely or untimely response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable.

Because there is no current fee guideline for ASC(s), the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence. As the requestor, the health care provider has the burden to prove that the fees paid were not fair and reasonable. In this case, the provider submitted EOB(s) from other carriers that indicates those carriers paid 100% of the billed charges. The willingness of some carriers to reimburse at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011(d) of the Texas Labor Code.

The provider's documentation fails to justify or demonstrate that the fees requested are fair and reasonable. Therefore, no further reimbursement is recommended.

The above Findings and Decision are hereby issued this 7th day of August 2002.

Denise Terry, R.N.
Medical Dispute Resolution Officer
Medical Review Division

DT/dt